



CANNON BUILDING  
861 SILVER LAKE BLVD., SUITE 203  
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE  
**DEPARTMENT OF STATE**  
DIVISION OF PROFESSIONAL REGULATION  
BOARD OF MEDICAL PRACTICE

TELEPHONE: (302) 744-4500  
FAX: (302) 739-2711  
WEBSITE: WWW.DPR.DELAWARE.GOV

<b>Recommendation from Chief of Staff or Chief of Service</b>																																																																						
Institution:			Applicant's Name:																																																																			
Address:			Address:																																																																			
City/State/Zip:			City/State/Zip:																																																																			
<b>This section is to be completed by applicant.</b>  <b>Be sure to sign the form.</b>	Last Name: _____ First Name: _____ SSN: _____ DOB: _____ Name if Different from Above: _____ Signature: _____ Date: _____																																																																					
<b>To be completed by Chief of Staff or Chief of Service</b>  Please indicate your evaluation of the following elements by placing a check mark in the appropriate column at the right. Please base your evaluation upon your personal knowledge or from the records maintained by your hospital.	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; padding: 5px;"><u>COMPLETION OF THIS SECTION IS MANDATORY</u></th> <th style="text-align: center; padding: 5px;">Unable To Evaluate</th> <th style="text-align: center; padding: 5px;">Below Average</th> <th style="text-align: center; padding: 5px;">Average</th> <th style="text-align: center; padding: 5px;">Above Average</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">1. Basic Medical Knowledge</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="padding: 5px;">2. Professional Judgment</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="padding: 5px;">3. Sense of Responsibility</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="padding: 5px;">4. Clinical Skills</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="padding: 5px;">5. Technical Skills</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="padding: 5px;">6. Cooperativeness, Ability to work with others</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="padding: 5px;">7. Medical Record Currency</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="padding: 5px;">8. Quality of Medical Records</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="padding: 5px;">9. Patient Management</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="padding: 5px;">10. Physician - Patient Relationship</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="padding: 5px;">11. I would rate this applicant's overall performance under my supervision, or based on hospital records as:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td colspan="5" style="padding: 5px;"> <b>Please explain your responses to "Unable to Evaluate" or "Below Average" on a separate sheet of paper.</b> </td> </tr> </tbody> </table>					<u>COMPLETION OF THIS SECTION IS MANDATORY</u>	Unable To Evaluate	Below Average	Average	Above Average	1. Basic Medical Knowledge	_____	_____	_____	_____	2. Professional Judgment	_____	_____	_____	_____	3. Sense of Responsibility	_____	_____	_____	_____	4. Clinical Skills	_____	_____	_____	_____	5. Technical Skills	_____	_____	_____	_____	6. Cooperativeness, Ability to work with others	_____	_____	_____	_____	7. Medical Record Currency	_____	_____	_____	_____	8. Quality of Medical Records	_____	_____	_____	_____	9. Patient Management	_____	_____	_____	_____	10. Physician - Patient Relationship	_____	_____	_____	_____	11. I would rate this applicant's overall performance under my supervision, or based on hospital records as:	_____	_____	_____	_____	<b>Please explain your responses to "Unable to Evaluate" or "Below Average" on a separate sheet of paper.</b>				
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<b>CERTIFICATION</b>  <b>***AFFIX INSTITUTIONAL OR NOTARIAL SEAL HERE</b>	I am licensed in the State of _____. I have known the applicant personally or professionally for the period _____ to _____. <div style="text-align: right; margin-right: 100px;">Month/Year                      Month/Year</div> _____ I recommend this candidate for licensure to practice medicine and surgery without reservation.  _____ I recommend this candidate for licensure to practice medicine and surgery with reservation.  _____ I <u>do not recommend this candidate for licensure</u> or to practice medicine and surgery.  Printed Name: _____ Signature: _____  Title: _____ Date of Signature: _____  Tel: _____ Fax: _____ E-mail: _____																																																																					

**\*\*\*RETURN COMPLETED FORM WITH SEAL AFFIXED TO THE BOARD ADDRESS ABOVE. THANK YOU. DO NOT FAX**